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Report of a Case, with Remarks.

BY

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REPRINTED FROM

The New York Medical Journal

for July 13, 1889.

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I was consulted on December 2, 1888, by Julia H., colored, aged twenty-seven, married, never pregnant; her menstrual flow always normal in quantity, regular and painless. Her symptoms, as related, consisted of great disturbance to digestion, pain and flatulence after eating, most obstinate constipation, dysuria, constant pain, and some tenderness over the lower region of the abdomen.

For the preceding three months, so great had been her distress from these various symptoms, her general health had become seriously impaired, and her weight, formerly 160 pounds, was now reduced to 120 pounds. About five years ago she discovered in the right inguinal region a lump of about the size of an orange. For several years it changed but little; four months ago, however, without any known cause, it was observed to be rapidly enlarging and assuming a more central position; at times on her turning over in bed the lump seemed to fall from one side to the other. Her general health had been perfect until disturbed by the growth of the tumor. Examination showed the abdomen to be distended to about the size of a six months' pregnancy. The enlargement was most prominent to the right

side. The tumor was smooth, globular, hard, inelastic, non-fluctuating, and freely movable—the area of dullness extending from the pubes to the umbilicus, from the right inguinal through the hypogastric to the left inguinal region.

Vaginal examination gave only negative evidence; the cervix was short, conical, and high. Nothing could be felt in either broad ligament. The sound passed four inches forward. Uterine hæmorrhage was not and never had been a feature of the case. In fact, there were no uterine symptoms *per se*. The symptoms were constitutional or remote, of which disturbance to digestion and nutrition was the most pronounced. These, together with the history of the growth and the physical signs, led to a diagnosis of subperitoneal fibroid tumor of the uterus, probably pedunculated. These growths ordinarily give rise to but little disturbance; in this particular case quite the contrary was true. Dependent largely upon her own exertions for support, she contemplated with dread a life of forced indolence, if not invalidism. Fortunately, she fully appreciated what the future had in store for her if the tumor was left undisturbed, and urged upon me its removal.

Considering the case favorable for hysterectomy and one in which the operation was clearly indicated, after most careful preparation of the patient I undertook the operation on December 8th last.

An incision about three inches in length was made in the middle line, the abdominal cavity opened, and the tumor with its surroundings explored. To my gratification, the diagnosis had been surprisingly correct. I found a subperitoneal fibroid of about the size of a child's head, movable, free of adhesions, springing from the upper and posterior aspect of the uterus; the attachment was somewhat pedunculated. The tumor had risen almost entirely out of the pelvis, drawing in its upward growth the uterus and appendages. It did not extend between the folds of the broad ligament, and, as before stated, adhesions were very slight—only one of consequence, that being omental.

The bladder in its relation to the uterus was normal; there was no adhesion of that viscus to the tumor. To complete the

picture, the left ovary was found lying well up on the side of the tumor, while the right lay in a mass of adhesions low in the pelvic cavity.

This case presented *in toto* all those supposable conditions which Greig Smith takes as illustrative of a typically simple case for hysterectomy. The operative procedure was so simple it is scarcely worth detailing. Enlarging the incision to one inch above the umbilicus, passing my hand from above under the tumor, with the aid of atmospheric pressure thus obtained I turned the mass out, Dr. Buist now holding it well up out of the cavity.

The left broad ligament with its ovary and tube lay high up on the side of the tumor in a position to be easily embraced with a serre-nœud. On the right side affairs were not so simple. The ovary was firmly imbedded in a mass of adhesions, the tube much enlarged; the relations of the appendages of this side were quite different from those of the left side. The right lay too low to be embraced by the wire; fearing too great tension on the ligament would cause it to slip from the grasp of the serre-nœud, which accident would certainly be followed by hæmorrhage from the proximal part, I deemed it at least prudent to leave the ovary undisturbed. The greater portion of the tube and broad ligament was doubly ligatured and divided. The left appendages being held close to the uterus, the wire loop was thrown around the mass, constricting the uterus about at the internal os. The wire was now tightened through Kœberlé's serre-nœud. Sponges were packed around the proposed pedicle, and the mass was cut away an inch and a half above the wire. There was no bleeding from the stump; however, the serre-nœud was immediately tightened by several turns of the screw. The stump was now trimmed of extra tissue. For want of better pins, two steel knitting needles were passed through the pedicle above the wire. The peritoneal cavity having been well protected, there was no need of irrigation or sponging, which is often done to excess. The pedicle was fixed in the lower angle of the wound. The abdominal wound was closed in the ordinary way down to the stump; here the parietal layer of peritonæum was stitched with interrupted catgut sutures to the peritoneal

covering of the stump below the wire. The stump was now treated with a saturated solution of perchloride of iron in glycerin. Iodoform gauze was packed under the clamp and pins to protect the cavity from any discharge from the pedicle. The patient was put to bed, having sustained but little shock. For forty-eight hours she suffered some from traction on the stump. The bladder was very irritable. A little morphine was given hypodermatically.

During the first twenty-four hours the clamp was tightened by a slight turn of the screw. On the second day the temperature was 101·8° F., and this was the highest during the progress of the case. On the seventh day the wound was dressed; everything was dry, sweet, and free from suppuration; the stump looked mummified.

On the day following I was surprised to find the dressing moist with the ichorous pus from the stump. There was no elevation of temperature. Her general condition was excellent. The parts were thoroughly cleansed with bichloride solution, dusted with iodoform, and packed well about with gauze to protect the cavity from contamination. The incision had healed beautifully down to the stump. Owing to the quantity of discharge, the pedicle was cleansed and dressed every day. The serre-nœud being occasionally tightened, on the twenty-first day after the operation the pedicle separated and the clamp was removed. Upon the separation of the pedicle a funnel-shaped depression an inch and a half deep was left. Through this the ligature applied to the right appendages came away. The hole rapidly filled in by granulation. The subsequent history of the case contains nothing of note. Five weeks after the operation there was a moderate menstrual flow. She recovered rapidly and has continued to improve in health and strength. The tumor weighed six pounds and three quarters. In its center there was a cavity containing about three ounces of clear fluid. I must here express my gratitude to Dr. Buist, Dr. Winn, Dr. Harris, and Dr. Wood, who upon this, as upon many other similar occasions, rendered valuable assistance, and encouraged me by their presence and indorsement.

Since performing this operation it has been my good fortune to observe the methods and results in abdominal surgery of several European operators, but more especially of my distinguished instructor, Dr. Granville Bantock, of London. All his work is characterized by system, simplicity, and dexterity. But it is in hysterectomy for massive fibroids with extensive adhesions and broad pelvic attachments, requiring careful enucleation, that the superior judgment and marvelous skill of this distinguished operator are shown to best advantage.

It is surprising how tolerant the peritoneal cavity is to the presence of large fibroids, even those in which extensive adhesions are almost certainly known to exist; patients wear their tumors with comparative grace and comfort.

Upon the other hand, in the case here reported, after the rapid growth of the tumor was awakened, its presence caused such distress from obstruction to blood circulation and the channels of nutrition, emaciation was so rapid, and physical pain and mental anxiety were so great, that some active procedure was imperative. True, all these symptoms may be alleviated, but I am convinced this was one of a large class in which total extirpation is the only resort. Yet Mr. Keith's proclamation is in some degree authoritative. He, in a very brief but pregnant communication to the "British Medical Journal," December 10, 1887, says: "I say it deliberately, hysterectomy is an operation that has done more harm than good, and its mortality is out of all proportion to the benefits received by the few."

A word of warning to the rash, a plea for conservatism, is always "vantage ground" chosen by the aged and experienced warrior. To his many successful hysterectomies, as much if not more than to any other operation, Mr. Keith owes his position of pre-eminence. In this same article,

above referred to, he indulges in no mean compliment to Apostoli. Was it enthusiasm over electricity rather than aversion to hysterectomy that induced him to utter so condemnatory a speech of an operation which from the point of view of necessity is as justifiable as any major operation?

Carefully study the description of some of Mr. Keith's hysterectomies requiring enucleation, one could never believe he would feel, with H. P. C. Wilson, of Baltimore: "I shrink and have a feeling of terror come over me when I find that I am obliged to perform hysterectomy" ("Trans. of the Am. Gynæc. Soc.," 1886).

Now that Apostoli's method is known to be suitable to only a few carefully selected cases, if not absolutely futile in all, and oophorectomy is unreliable and often wholly impracticable, what are we to do for women dying—and they do die—from fibroid tumors?

Greig Smith, basing his conclusions upon the results obtained by Bantock, Thornton, and Tait, regards it a justifiable procedure. Again, the mere fact that these surgeons are constantly doing the operation speaks for their belief in the necessity and faith in results.

In a study of this operation surgeons are still perplexed as to how best to treat the pedicle. We can affirm upon authority that Keith, Bantock, and Hegar have by the extraperitoneal method attained results unequaled by "any one, or any combination of operators by the intraperitoneal method." Notwithstanding this, Keith says: "The principle of extraperitoneal or clamp method may seem to be the better, but on this point experience has made me change my mind."

Granting the serre-nœud to be crude and unsurgical, and being fully convinced that some method of safe intraperitoneal treatment will be found, one can not study the re-

sults at the Samaritan Hospital and question the superiority of the extraperitoneal treatment over any known intraperitoneal ligation and suture, whether it be simply Schroder's plan; or after the ingenious method of Dr. Polk, in which, when complete, the stump is intra-abdominal yet extraperitoneal; or the combined abdominal and vaginal method, accredited, I believe, to Dr. Mary Dixon Jones; or, later, the interparietal method of Hacker; or, still more recent, the new method of Kelly.

One can with comparative ease graphically describe most surgical operations; a nephrectomy or ligation may be depicted step by step, and, whilst no two operations are exactly alike, their details are very similar. Not so with hysterectomy. Note the vast difference between an ordinary supravaginal amputation of the uterus for a non-adherent fibroid and for one growing out in the broad ligaments, rising up into the abdominal cavity, adherent to everything, short at the base, without a pedicle, requiring the elastic ligature and the most difficult enucleation, each step testing the skill, knowledge, and patience of the surgeon. So variable are the complications met with in fibroid growths that the surgeon who attempts their removal by any proscribed plan or principle other than those broad principles upon which all surgical technique is based will find he will often have to abandon his undertaking in despair. Dr. Wylie fully appreciates this when he says: "Each case must be a law unto itself." Experience alone will enable us to cope with the difficulties that are met with.

Without presuming to be in the least critical, I can but remark the sweet simplicity of the case by which Dr. Howard Kelly illustrates his new method of intraperitoneal and extraperitoneal treatment of the stump ("Am. Jour. of Obstet.," April, 1889).

The special features of the operation for which he claims originality are:

1. The last row of interrupted sutures are left long for the purpose of elevating the stump should hæmorrhage occur.

2. The subperitoneal ligation of the uterine arteries as they ascend on the cervix.

3. The important but not original method of closing the abdominal incision about the stump.

"If," says the writer, "the broad ligaments are spread out on the tumor at the side, they are tied off in a double row of ligatures down to the base of the tumor." In my own limited experience and unusual advantages of observing at the Samaritan Hospital, this primary step of freeing the tumor from the folds of the broad ligament which Dr. Kelly treats so lightly is the greatest difficulty and obstacle to the operation. When such a condition is present, enucleation is necessary. A pedicle must be formed; the stump may be from two to four inches in diameter.

Fig. 4 in Dr. Kelly's article is only diagrammatic, of course; quite like the stem of a toad-stool; in no way resembling an ordinary fibroid.

Dr. Kelly treats the stump after Schroeder's plan, except that the last row of sutures approximating the peritonæum are left long. The stump is then held aside while the operator ligates the uterine arteries subperitoneally. Can the surgeon forget that the pathological is but the perversion of the normal; that in so much as the cells and fibrillæ are increased and distorted in the hyperplastic process, just so is the anatomy destroyed?

Given a large, soft fibroid, where are the uterine arteries? Can it be hoped that one thrust of the needle, one bite of peritonæum, will embrace the artery? Surgery is a science, not a chance shot.

The next step is that of stitching the parietal peritonæum about the stump. This all operators endeavor to do after some fashion, relying, however, upon the clamps and pins to support the pedicle, upon which oftentimes there is great traction. Dr. Kelly relies upon the forceps and sutures to hold the pedicle up. It appears to me that the tension would soon cause the sutures to cut through and the stump, a sloughing mass, to sink down, and that into the peritoneal cavity.

The objections to Dr. Kelly's method are :

1. It is not applicable to a fibroid growing low on the uterus or spreading out in the broad ligaments.

2. Unless the pedicle was unusually long, separation from the parietes would soon occur.

3. The uterine arteries can not be definitely located. In case they were not grasped by the ligature, hæmorrhage would certainly supervene.

4. Should hæmorrhage occur in spite of precautions taken, forcible elevation of the stump would be attended by obvious dangers.

5. The method is so intricate that the operation would necessarily be a prolonged one.

In a communication to the "Am. Jour. of Obstet." from T. J. Crofford, M. D., commenting unfavorably upon this and all other methods now in vogue of doing hysterectomy, that writer reports a case in which he successfully removed the entire uterus, his aim being to "leave no pedicle of uterine tissue, and there is no necessity to fasten the stump anywhere."

I believe he claims originality for this method. It is nothing more than Bardenheuer's modification of Freund's operation, abandoned on account of high mortality. "Thus, step by step, the way was paved for the vaginal method."—*Sutton.*

No one having had the care of an extraperitoneal stump can fail to wish for some improvement. Dr. Polk, by his modification of Bantock's plan, comes nearer solving the problem. Yet in Dr. Dudley's case, treated after Polk's method, there was slight hæmorrhage on the fourth day, and the patient subsequently died.

REASONS WHY

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EDITED BY FRANK P. FOSTER, M. D.,

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